STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: _____ B. WING _____	07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	Initial Comments A re-licensure survey was conducted by the Office of Health Care Assurance (OHCA) on 07/23/19 - 07/26/19. The facility was found not to be in substantial compliance with Hawaii Administrative Rules, Chapter 11-94.1 Survey Dates: 07/23/19 - 07/26/19 Survey Census: 78 Sample Size: 36 Supplemental Residents: 0	4 000		
4 101	11-94.1-22(c) Medical record system (c) The following information shall be obtained and entered in the resident's record at the time of admission to the facility: (1) Personal information such as name, date, and time of admission, date and place of birth, citizenship status, marital status, social security number, or an admission number that can be used to identify the resident without use of name when the latter is desirable; (2) Name and address of next of kin, legal guardian, surrogate, or representative holding a power of attorney; (3) Sex, height, weight, race, and identifying marks; (4) Reason for admission or referral; (5) Language spoken and understood; (6) Information relevant to religious affiliation, if any; (7) Admission diagnosis, summary of prior	4 101		8/23/19

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4 101	Continued From page 1 medical care with listing of physicians providing care, recent physical examination, tuberculosis status, and physician's orders; and (8) Advanced directives, as applicable. This Statute is not met as evidenced by: Based on record review, interview with staff members, and review of the facility's policy and procedures, the facility failed to ensure advance directives were maintained in the medical record for 2 (Residents 48 and 62) of 11 residents sampled. Findings include: On the morning of 07/24/19, a record review found no documentation of Resident (R)48 and R62's advance directive. On 07/25/19 at 08:36 AM concurrent record review was done with the Social Worker (SW). The SW confirmed R48's advance directive was not in the chart. The SW reported R48 was readmitted for respite while on vacation. The SW also confirmed R62's advance directive was not in the chart. The SW recalled R62 went to the hospital and the advance directive was probably sent with the resident. The SW was agreeable to check her files and the business office for copies. On 07/26/19 at 08:53 AM, the SW provided a copy of R48's durable power of attorney for financial management. The SW reported R48's family provided a copy of the document on 07/25/19. The SW was unable to locate an advance directive for R62. The SW stated she is positive R62 has an advance directive and contacted R62's family. The family member will bring a copy next week. The SW explained the	4 101	Corrective Action: Resident #48 has discharged. Resident #62 has an advanced directive in his chart. Identification of others: Facility wide audit was performed by social services for Residents with advanced directives to ensure they are filed into the Residents chart. No others were affected. Systemic Changes: Staff Development Coordinator or designee educated Admissions, Medical Records, Social Services and Business Office associates on advanced directives policy. The admissions department will notify SW to ensure an advanced directive is present in the chart upon admission and follow up with the family regarding advanced directives. A duplicate copy of the advanced directives will be in social services and business office files. Monitoring: Social Services Director or designee will audit new admission charts to ensure an advanced directive is placed in the residents chart as applicable. Audits will occur weekly x 4 weeks and monthly x 3 months. Audit results will be presented to the QAPI committee for ongoing oversight.	

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4 101	Continued From page 2 facility keeps three copies of residents' advance directives, one is in the residents' charts, the second is filed in the SW office, and the third copy at the business office. On 07/26/19 the facility provided a copy of the policy and procedure entitled "Advance Directives", revised 02/2018. The policy notes the following: "...if the resident has an advance directive, the social worker will request a copy of the directive so that it may become part of the medical record...Note: The advance directive copy should always remain in the resident's record, protected in a plastic cover, even if the chart is thinned".	4 101		
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on a confidential family interview and record review, the facility failed to ensure a resident had a right to a dignified existence.	4 115	Corrective Action: Education was provided to staff regarding communication during care.	8/23/19

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4 115	Continued From page 3 Findings include: On 07/23/19 at 12:45 PM a confidential family interview was done. The family member shared observation of some staff members providing care found they do not acknowledge the resident's presence by speaking to the resident. The family member further shared some staff members speak to the resident and others don't talk too much. A record review found a care plan was developed to address the potential for social isolation related to impaired cognition. The intervention included "all staff to converse with [name of resident] while providing care".	4 115	Identification of others: Interviews were conducted by Executive Director with family members and Residents regarding communication during care. No others were affected. Systemic Changes: Staff will greet residents prior to providing care and during other interactions throughout the day. Education had been provided to staff to include talking with resident who may not be able to speak or who may not seem to be able to understand what is being said. Monitoring: DON or designee will audit 10 Residents weekly x 4 weeks then 10 Residents monthly x 3 months. Audit will occur during care to ensure a dignified experience and communication is provided by staff. Audit results will be presented to the QAPI committee for ongoing oversight.	
4 152	11-94.1-39(e) Nursing services (e) There shall be a policies and procedures manual that is kept current and consistent with current nursing and medical practices and approved by the medical advisor or director and the person responsible for nursing procedures. The policies and procedures shall include but not be limited to: (1) Written procedures for personnel to follow in an emergency including: (A) Care of the resident;	4 152		8/23/19

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4 152	Continued From page 4 (B) Notification of the attending physician and other persons responsible for the resident; and (C) Arrangements for transportation, hospitalization, or other appropriate services; (2) All treatment and care provided relative to the resident's needs and requirements for documentation; and (3) Medication or drug administration procedures that clearly define drug administration process, documentation, and authorized This Statute is not met as evidenced by: Based on record review and interview with staff member, the facility failed to ensure 1 (Resident 62) of 5 residents reviewed for unnecessary medication review was monitored for efficacy for the use of trazodone to treat a sleep disorder (insomnia). Findings include: Resident (R)62 was readmitted to the facility on 07/02/19 following hospitalization for bilateral pneumonia. R62's diagnoses include dementia and depression. A record review on 07/25/19 at 12:42 PM found a physician's order for trazodone HCl tablet, 150 mg at bedtime related to sleep disorder. The facility developed a care plan to address R62's alteration in sleep pattern (inability to fall asleep for 6-8 hours a night). The record review found no documentation of monitoring of the number of	4 152	Corrective Action: Hours of sleep for Resident #62 is in place for nurses to monitor. Identification of Others: House wide audit was conducted and no others were affected. Systemic Changes: Education was provided to LN's regarding the policy to monitor hours of sleep if a Resident is prescribed a sleep aide. DON or designee will review all new orders given for sleep aides to ensure hours of sleep are monitored and initiated on the MAR. Monitoring: DON or designee will audit 10 charts weekly x 4 weeks and 10 charts monthly x 3 months. Audits will be presented to the	

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4 152	Continued From page 5 hours of sleep for R62. On 07/25/19 an interview was conducted with Unit Care Coordinator (UCC). The UCC was asked whether the facility is monitoring R62's sleep as the resident receives trazodone for sleep disorder. The UCC replied the facility does monitor R62's number of hours of sleep. The UCC reviewed the unit's behavior monitoring folder and found R62 did not have a monitoring sheet for sleep. The UCC confirmed R62 should be monitored for the number of hours of sleep he has nightly to assess the efficacy of the trazodone.	4 152	QAPI for ongoing oversight.	
4 243	11-94.1-64(a) Engineering and maintenance (a) The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations, resident interview, and staff interview, the facility failed to identify a potential electrical accident hazard for one (Resident (R) 33) of eight residents reviewed. As a result of this deficient practice, the facility put the safety and well-being of all the residents as well as the public at risk for accident hazards, such as a fire. Findings Include: During an observation of Resident (R) 33's room, on 07/23/19 at 10:41 AM, two electrical power strips were connected, in sequence, when plugged in to one power source/electrical outlet. The first power strip (from the wall outlet) had two items plugged in: 1. the bed, and 2. cable box.	4 243	Corrective Action: R #33's power strip was removed from room on 7/24/19. Identification of Others: House wide audit was conducted on 7/24/19 to identify if any other power strips were being connected in sequence when plugged into once source/electrical outlet. No others were identified. Systemic Changes: Education was provided for staff regarding power strips in Resident rooms. "Guardian Angel" rounds that Managers perform have an added task to include looking for power strips in rooms that are not being	8/23/19

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4 243	Continued From page 6 The second power strip (which extended from the first) had two additional items plugged in: 3. a lamp, and 4. television. During a second observation of R33's room on 07/24/19 at 08:30 AM, the findings were the same as previously described on 07/23/19 at 10:41 AM. R33 was admitted to the facility on 10/29/18 with a diagnosis of leg cellulitis, peripheral vascular disease, diabetes, chronic pain, congestive heart failure, kidney disease, cardiac arrhythmias, depressive disorder. R33 was awake, oriented to person, place, and answering questions appropriately at the time of interview on 07/24/19 at 08:30 AM. R33 said that only one wall outlet was working so that was the reason for using a second power strip. On 07/25/19 at 09:56 AM, the Environmental Services Director (ES Dir) was queried about the above findings. ES Dir acknowledged that the two power strips should not have been connected to one another because the potential for a circuit overload and/or electrical fire.	4 243	utilized properly. The Resident handbook that new admissions receive had been edited to include on the fire safety page information regarding power strips in resident rooms. Resident Council has been informed of the rules regarding power strips in Resident rooms. Monitoring: Director of Environmental services or designee will audit 10 rooms weekly x 4 weeks and then 10 rooms monthly x 3 months. Audits will be presented to the QAPI committee for on-going oversight.	